Wisconsin Department of Health and Family Services

Pharmacy NewsCapsule

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LTC Surveyor Updates

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Clarification of Scoring for Medication Investigation

Medication pass task is a surveyor observation of medication administration in a nursing home and is required during each annual nursing home survey. The Federal Centers for Medicaid and Medicare Services (CMS) recently released Survey and Certification Letter 04-30 to clarify how states are evaluated by CMS when completing the medication pass task. In most cases, Wisconsin Surveyors have been following the appropriate medication pass task procedures and the State has been scoring well in this area. Below are three important points from the letter that also relate to recent Federal Oversight Survey results.

First, please note that in order to score a "5", the sample used must be reflective of the sample of residents that were chosen for the survey. The residents in medication pass do not need to be the residents chosen for the sample but must have similar characteristics. (i.e. quality indicators)

Second, CMS clarified that if a second round of medication pass investigation is needed, there must be 20-25 opportunities in the second round, no matter how many opportunities were observed in the first round.

Third, the medication pass investigation must be planned to obtain observations of all routes of medication administration. If this is planned, but other survey tasks or facility interventions prevent the surveyor from obtaining these observations, this should be discussed by the survey team. Missing routes that were planned will not be held against the survey team when CMS evaluates the survey.

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See "Beer's list"

Inside This Issue

Miscellaneous Zyprexa News:

A recent case report documented neuroleptic malignant syndrome in a 49-year-old woman. The woman had been on Zyprexa 5 mg for four months and recently started Paxil for depression. Two weeks after starting Paxil she visited the hospital and the diagnosis of neuroleptic malignant syndrome was made. The authors of the case ruled out a specific drug-drug interaction as the potential cause.

There are growing reports of similar movement problems with selective serotonin reuptake inhibitors (SSRI) when used in combinations with antipsychotics. Facilities and survey staff should be aware of potential adverse events from SSRIs especially when used in combination with antipsychotics.

New Drugs

Doug Englebert Pharmacy Practice Consultant PRQI

Brand Name	Generic Name	Use
Alimta	Pemetrexed	mesothelioma
Apokyn	Apomorphine	hypomobility in Parkinson's
Avastin	Bevacizumab	colorectal cancer
Erbitux	Cetuximab	colorectal cancer
Ketek	Telithromycin	respiratory infections
Sensipar	Cinacalcet	hyperparathyroid in dialysis patients
Spiriva	Tiotropium	COPD
Apidra	Insulin glulisine	RAPID ACTING INSULIN
Zyprexa IM	Olanzapine	See focus drug of month

Medication Errors

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A lot of facility risk management activity this year, related to potential medication errors, surrounds the use of various abbreviations. The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) has pushed an abbreviation elimination initiative through its requirements for accreditation and its Patient Safety Goals.

Surveyors may see many different activities occurring, especially in hospitals, to avoid the use of specific abbreviations. Occasionally, surveyors may be asked to share ideas about abbreviation programs they may have previously seen. The best resource for these types of questions is the JCAHO web site at: www.jcaho.org/accredited+organizations/patient+safety/04+npsg/tips.htm. Surveyors should refer facilities to this site.

This web site has over one hundred examples of how various facilities have implemented systems to eliminate dangerous abbreviations. Facilities struggling in this area may find some great ideas for implementation.

Focus Drug of the Month

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Zyprexa(olanzapine)

Zyprexa IntraMuscular was recently approved for agitation associated with schizophrenia and Bipolar I Mania. This product is not approved for agitation associated with dementia.

Zyprexa comes in a 10 mg vial and must be reconstituted. Once reconstituted it must be used within one hour. For geriatric persons, the dose may go down to as low as 2.5 mg. Repeated doses of Zyprexa Intramuscular has not systematically been evaluated in controlled trials and therefore efficacy has not been established. In addition, repeated doses may be associated with increased risk of orthostatic hypotension. Therefore, repeated doses should not be seen.

Because of the cost of the drug, limited indications for use and stability of the product, nursing homes and other facilities may limit or eliminate the use for elderly residents. If surveyors see the drug being used, they should remember that there is not a regulation that states intramuscular products cannot be used. It is a "red flag" for surveyors to consider whether the medication is being used as an inappropriate chemical restraint. Inappropriate chemical restraints are those used for punishment or staff convenience.

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Beer's List

Continued from page 1 LTC Update

The Beer's list is the list of medications that CMS adopted in the State Operations Manual for surveyor guidance directing surveyors to critically review those medications. The Beer's list was updated in December 2003 but not adopted by CMS. The medications listed in the Guidance to Surveyors under F329 and F429 were previously based on the Beer's criteria from 1992 and 1997. So what does the updated list mean?

PLEASE REMEMBER THE BEER'S LIST IDENTIFIES DRUGS THAT ARE **POTENTIALLY** INAPPROPRIATE. FACILITIES CAN STILL USE THESE MEDICATIONS, BUT THEY MUST BE AWARE OF THE POTENTIAL PROBLEMS, JUSTIFY THE RISKS AND BENEFITS AND MONITOR THOSE RISKS.

Although CMS has not provided specific direction on using the new list, particular attention should be given to those medications that have been removed from the list and those items that are on the list with changes. DHFS will send out an updated resource sheet with the new information that should be used as a resource to the CMS State Operations Manual. Use of the resource list will be a Wisconsin initiative only.

It is important that surveyors learn the new items on the list. In most cases, use of many of the medications listed has already been monitored by survey staff, so there should not be a significant change in survey activities.

PA and Timely Services

Please remember that according to CMS regulations, nursing homes must provide "timely services." CMS has not specifically defined "timely services" so many rumors have floated around on what that means, i.e. 24 hour pharmacy service, medications received within 4 hours of the order being written, 8 hours within time order was written, etc. To determine if a medication service is timely, a surveyor must include evidence in the investigation related to the medication and to the resident's condition or expectation. In addition, the investigation must take the physician's expectations into consideration. For example, on a Friday evening a physician may order a cholesterol medication. The resident has probably had high cholesterol for some time and the medication itself may not begin to work for quite a few days. In this instance, starting the cholesterol medication immediately is not required. In this case timely may mean starting the medication on Monday or Tuesday. Another example may be a resident who is screaming in pain and waiting for pain medication. Waiting three days is not timely. The resident's needs must be met immediately in this case.

To establish if the chemical restraint was used for staff convenience, surveyors need to determine if the facility determined that the agitation was a potential harm to the resident or others and if other interventions were attempted first. If those issues are not addressed, the surveyor must decide whether the evidence requires a citation for inappropriate chemical restraints.

In addition to Zyprexa Itramuscular being approved, the labeling warnings have been changed. All Zyprexa products now carry a warning related diabetes mellitus and hyperglycemia. The warning indicates that individuals with diabetes who take Zyprexa should be monitored regularly for worsening glucose control. Persons at risk of diabetes who take Zyprexa should have base-line fasting glucose completed and periodic tests during treatment. Signs and symptoms of hyperglycemia (weakness, extreme thirst, excessive eating and excessive urination) should be monitored.

Newer antipsychotic medications are still being studied and providers should be aware that the data might end up showing a hyperglycemia/diabetes mellitus warning is warranted for all of the new antipsyhotics. In the meantime, providers should be aware of the potential problems and address issues when necessary.

If there are medications you would like featured in this column, please send an email to Doug at engleda@dhfs.state.wi.us

Consultant's Corner

Doug Englebert *Pharmacy Practice Consultant PRQI*

This section will appear in each issue and will contain information that will answer your questions. If there is a topic about which you want more detailed information, please drop me an email at engleda@dhfs.state.wi.us and I'll research the topic.

1. *When a Community Based Residential Facility (CBRF) resident has their prescription instructions changed, how do we change the label to be the same as the instructions?*

The need to have the label match the written order depends on the facility's system. Some facilities rely on written order, while others rely on the label when administering medications. If a facility relies on the label and the label does not match the order, there is a need to change it or at least have a system in place to warn the person administering medications that the label is incorrect. Pharmacies are unable to fax or send a label change to the facility. So, facilities need to have an alternative plan in place. The medication could be sent back to the pharmacy to be relabeled, although that is often difficult, as the medication then needs to leave the facility. Most facilities simply mark the label as incorrect and will make sure the next month's supply will have a correct label. The mark on the label informs staff to refer to the current, correct order.

2. *Some facilities label eye drops with the date opened. Is this required?*

Typically, facilities will mark medications with the date opened if the medication has a shorter expiration once it is opened. Most eye drops do not have shorter expiration dates. The facility may be doing this out of habit or it is possible that the facility has concern with infection control, related to eye drops, and is conservatively using the eye drops for a shorter time frame than what the manufacturer allows.

3. *We observed a facility measuring all liquid medications with a medication cup that did not have graduations marked for the quantity that was required. For example, the dose of medication was to be 7.5 ml, but the cup is only marked at 5 ml and 10 ml. That staff person being observed indicates they just pour to halfway in-between the 5 ml and 10 ml mark for the 7.5 ml dose. Do we count this as a medication error?*

It appears that the facility is guessing that the dose they prepared is correct. The facility should use a device that accurately measures the dose that is needed. In this case, just as when a facility staff fails to shake a suspension leading to potentially the wrong dose, this improper measuring should be counted as a medication error.

4. *Can a home health nurse deliver a patient's controlled medications?*

Assuming the controlled medications have been dispensed by a pharmacy, the home health nurse could be an employee of the pharmacy or considered the agent of the patient and therefore could transport the controlled medication to a resident's home. The home health nurse should take appropriate precautions to protect security of the medications. If the medications were stolen or lost, appropriate persons should be notified, including local police.

References are available upon request.